

Using the Developmental Counseling and Therapy Model to Work With a Client in Spiritual Bypass: Some Preliminary Considerations

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At a time when attention to spirituality within the counseling profession is unparalleled, 1 potential problem is that clients who engage in spiritual bypass will be supported in this dysfunctional pattern by their counselor. The purpose of this article is to define and describe spiritual bypass and to discuss the use of the developmental counseling and therapy model to assess and intervene with a client who is in spiritual bypass.

Although recent attention to the infusion of spirituality into the counseling process is unparalleled in the history of the counseling profession, there is an ongoing need to consider the potential dangers of this trend. Many writers have focused on the importance of counselor competence in addressing client spirituality (Burke et al., 1999; Miller, 1999; Myers, Sweeney, & Witmer, 2000). More recently, there has been a major focus on spirituality as one aspect of a person's culture (Fukuyama & Sevig, 1999) and development (Fowler, 1981; Young & Cashwell, 1998); culture and development are core curricular areas for the Council for Accreditation of Counseling and Related Educational Programs (2001). Although scholars have sought to distinguish between psychologically healthy and psychologically unhealthy spiritual practice for over 100 years (James, 1901), there has been a recent proliferation of writing and research attempting to make this distinction (Arteburn & Felton, 1992; Booth, 1991; Gorsuch, 1988; Kirkpatrick, 1997; Nielson, Johnson, & Ellis, 2001; Pargament, 1997; Seybold & Hill, 2001; Sperry, 2001). Despite this increasing recognition of the importance of spirituality in the counseling process, one area that has received limited attention in the counseling literature is spiritual bypass.

In this article, we define spiritual bypass and provide case examples to illustrate the complexity of this phenomenon. Traditional theoretical perspectives that purport to clarify the dynamics of spiritual bypass and the methods of intervention arising from these theories are explained, with emphasis on the need for metatheoretical approaches. Developmental counseling and therapy (DCT; Ivey, 1991, 2000) is described as an appropriate and effective method for assessment, intervention, and treatment planning with clients who are experiencing spiritual bypass.

SPIRITUAL BYPASS DEFINED

Spiritual bypass refers to the use of spiritual experiences, beliefs, or practices to avoid (or bypass) psychological wounds and other personal and emotional unfinished business, in essence rejecting these experiences (Welwood, 2000; Whitfield, 1987, 1991). The term *premature transcendence* also appears in the literature (Elliott, 1997; Harris, 1994; Sovatsky, 1998) and seems to be synonymous with spiritual bypass. Spiritual bypass commonly occurs when people become polarized in their thinking that "human" issues are not important, and relationships and other aspects of day-to-day life often are neglected as a result of the bypass (Sovatsky, 1998). Spiritual practice remains compartmentalized and unintegrated, and a gap exists between the sophistication of the spiritual practice and the level of personal development (Welwood, 2000). This polarization of spiritual practice as a higher realm and psychological work as a lower realm is problematic because freedom and the end of suffering are most available through integrating these two aspects of life (Kornfield, 1993). Spirituality is not meant to help a person avoid life problems and dilemmas; rather, within many spiritual traditions, there is an emphasis on living an ordinary life complete with the inevitable suffering (West, 2000). Unfortunately, this polarization may in part be fed by the reluctance of many clergy and mental health professionals to work collaboratively (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998).

From a psychological standpoint, spiritual bypass involves a cutoff of important unfinished business. The spiritual identity becomes the individual's persona while the unfinished psychological business, considered too undesirable by the person to acknowledge, is repressed and relegated to the "Shadow." Numerous authors have written of the Shadow

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as the compensatory function of the unconscious and of the perils of these unresolved issues (Harris, 1994; Johnson, 1991; Jung, 1959; Vaughn, 1995; Welwood, 2000). In essence, these unresolved conflicts cannot remain unexpressed without serious results and often create tremendous intrapsychic conflict as a person's self-image becomes distorted and inaccurate (Epstein, 1994; Wilber, 1994), a process that has "fateful and pathological consequences" (Engler, 1994, p. 120).

Spiritual bypass, although often an unconscious "path," is used to avoid many of the major mental health issues. Most notably, spiritual bypass may be used to compensate for low self-esteem, anxiety, depression, narcissism, and dependency issues (Welwood, 2000). The problem is that the "new" spirit-filled behaviors are actually extensions of the unfinished psychological business. As one example of this, a person who is inclined toward social isolation because of pervasive thoughts and feelings of inadequacy may be drawn to spiritual writings and teachings that promote detachment and renunciation (Welwood, 2000). Similarly, people may use their spiritual beliefs to justify compulsive goodness. When we act in a compulsively good way because of spiritual bypass, however, we

compensate for inner feelings of worthlessness. As compulsively good people, we act good because we have difficulty standing up for ourselves and respecting our own intuitive knowing and feelings. We are good because we cannot express anger, ask for what we want, refuse what is requested of us, speak up for ourselves, know what it is we want, trust in our own perceptions, or express any other form of self-interest. Our goodness is motivated by a fear that we will be criticized or disliked. It covers up an unconscious need for self-rejection, self-neglect, and represents a fear of connecting to ourselves and a resistance to being ourselves. (Michaelson, 1999, p. 2)

Similarly, people in spiritual bypass may use the teaching of their particular spiritual leaders to justify the repression of anger. Although compassion and forgiveness are goals of many of the major world religions and spiritual practices, compassion can most fully be experienced in the absence of anger, not when anger has been disowned and repressed. Similarly, disowning and repressing experiences of fear may also occur.

Another common outcome of spiritual bypass is spiritual narcissism or ego inflation (Ellis, 2000b; Rosenthal, 1987; West, 2000). This occurs when persons with high ego needs or, in the extreme case, narcissistic individuals engage in spiritual practice and seek spiritual experiences as a way to feel superior to others who do not have these transcendent experiences. Other possible outcomes of spiritual bypass are spiritual obsession/addiction (Booth, 1991), blind faith in charismatic teachers, spiritual materialism (i.e., using spiritual practice for material gain; Welwood, 2000), and abdication of personal responsibility.

CASE EXAMPLES OF SPIRITUAL BYPASS

To exemplify the types of problems that can emerge when spiritual bypass occurs, we offer the following case examples from our clinical and counselor education practices. The diversity of problems represented underscores the need for

accurate assessment when problems of spiritual bypass arise in the counseling process. The ease of misdiagnosis of core issues is evident in each of these cases, leading to interventions that ignore, and thus fail to treat, core spiritual bypass issues. A brief discussion of traditional counseling approaches at the conclusion of each case underscores this point.

Case Example 1: "The Good Servant"

Kim joined a church in her community that had a strong "hands-on" ministry. She became extremely involved in serving shut-ins and older adult members of the church and community. She spent extensive amounts of time and money in her service endeavors and received volunteer awards from the church and community and many more personal accolades from members of her church. Her husband and children complained about her lack of support for the family and lack of availability to the family, but she responded that she was following a "call" and therefore had to continue what she was doing. When her husband asked for a separation weeks later, she berated him for not understanding her "call" and stated that she thought the separation was a good idea because it would afford her more time to devote to her service to the church.

Although her service to the community is admirable, it should be considered in the context of her psychological history. Kim was raised in an alcoholic family where she experienced little intimacy in relationships with members of her family of origin. Also, because of the instability of her original family environment, she has always expended great energy trying to please others and win their acceptance. As a result of these original family dynamics, Kim struggled with her most intimate relationships (with her husband and children) and provided service to the church both to avoid these intimate relationships and to gain the admiration of members of her church. Ignoring the family of origin issues, the pastoral counselor at Kim's church assessed her behaviors as being addictive and referred her to a 12-step program.

Case Example 2: "Turn the Other Cheek"

David sought a consult with a spiritual leader in his community about anger that he felt toward his wife. The spiritual leader cited several passages from holy texts that promoted compassion and temperance and encouraged David to be more compassionate and less angry toward his wife. David readily accepted this advice, in part because it fit with defenses he had used in the past. David, a victim of severe physical and psychological abuse from his mother, learned early in life to "swallow" his anger. Although he provided sound practical advice, this spiritual leader unknowingly reinforced David's unhealthy coping strategy. David also participated in counseling oriented toward reducing his anger. David learned cognitive approaches such as *thought stopping* and *reframing* and was able to better control his anger responses.

Case Example 3: "I Have a Gift"

Joanna began training in a counselor education program. Throughout her early studies, program faculty expressed

concerns about her frequent disclosures of abuse history and her apparent anger toward men. She left the program prior to completing her internships. She opened a "retreat center" in the local community and began providing "spiritual counseling" to women. When confronted by program faculty members about this inappropriate activity, she responded, "I don't need training. I have a God-given talent; it's a gift." Joanna also explained that she had seen a transpersonal counselor who had used experiential focusing (Gendlin, 1982) to help her to be more in touch with her feelings of enlightenment and who reinforced her spiritual persona. Faced with potential action from the state licensure board, Joanna found a church that ordained her so that her practice was in compliance with state laws.

TRADITIONAL APPROACHES TO ASSESSMENT AND INTERVENTION

Clinical interventions for each of the cases just described began with an assessment (which did not include spiritual bypass) of the presenting problem, proceeded through conceptualization of the client's issues according to accepted theoretical perspectives, and resulted in the implementation of a treatment plan. Interventions for these clients were framed according to addictions theory, cognitive behavior and rational emotive behavior therapy, and experiential focusing, respectively.

In the first case example, the client sacrificed her family and personal life in service to others, evidencing what Michaelson (1999) termed "compulsive goodness" (Compulsive Goodness section, ¶6), one potential outcome of spiritual bypass. Her behaviors may be viewed as arising from a process addiction and reflect the codependency characteristics that are common in adult children of parents with alcoholism. Bibee (2000) described this constellation of issues as resulting from spiritual bypass that, similar to other addictions, includes elements of denial and magical thinking. He also noted that engaging the client in a 12-step process results in the "solution" of turning the outcome over to his or her Higher Power. What is really bypassed at that point is the client's spiritual struggles, resulting in a need in the later stages of recovery to "unravel one's codependent relationship with God" (Bibee, 2000, p. 2).

As seen in the second case example, cognitive approaches are seemingly a ready "fit" for clients struggling with problematic spiritual issues. Cashwell, Young, Cashwell, and Belaire (2001) conducted a study of the effects of including spiritual process in counseling and concluded that a spiritual intervention was perceived similarly to a cognitive behavioral intervention among 228 clients. At the same time, Ellis (2000a) reminded us that some types of religious expression are helpful and some are harmful. "Dogmatic and absolutistic religiousness . . . tend to be emotionally harmful" (p. 29). David received both appropriate spiritual guidance and counseling interventions known to be effective in anger management, yet these interventions allowed him to "bypass" his deeper psychological needs and avoid dealing with the reasons underlying his distress.

In the third case example, experiential focusing (Gendlin, 1982) was used to help the client become more aware of her inner experience, and particularly her *felt body* experience. From a humanistic-existential perspective, helping clients attend to inner experience is quite appropriate. However, spiritual bypass is evident in the client's attempt to achieve "premature transcendence" (Elliott, 1997, p. 22) while avoiding dealing with current conflicts, both internal and external.

These brief examples demonstrate the complex nature of spiritual bypass and the ubiquitous characteristics of this process. Spiritual bypass exists in concert with other aspects of functioning, just as our spiritual and earthly selves coexist. Thus, by treating only the psychological maladjustment, or even the spiritual issues, in isolation from other characteristics of one's personality, we, as professional counselors, risk encouraging both the development and the continuance of bypass. Metatheoretical perspectives that incorporate spiritual functioning as a component of normal developmental processes are needed to foster an integration of all aspects of the self. Developmental counseling and therapy, or DCT, is one viable theory that offers promise in this regard.

DCT: AN OVERVIEW

DCT (Ivey, 1991, 1999, 2000) is a relatively new counseling theory that is based on a metaphorical use of Piaget's (1952) cognitive stages. Concepts arising from individual developmental theories (e.g., Erikson, 1963; Gilligan, 1982); family theories (e.g., Haley, 1980); and multicultural theories, including racial and sexual identity development (e.g., Sue, 2002), are integrated in a metatheory based in human development over the life span. Ivey (1991, 1999) proposed that developmental theory and counseling can be integrated (Crespi & Generali, 1995). Thus, he developed a systematic model that incorporates understanding the meaning of a client's cognitive developmental functioning, assessing the nature of that functioning, and selecting interventions in an intentional manner to address specific needs of clients in relation to identified and coconstructed issues (Ivey & Goncalves, 1987, 1988). A brief overview of the theory provides a foundation for understanding developmental blocks as well as the processes of assessment and intervention.

Similar to Piagetian theory, Ivey's (1991) theory identified four modalities or levels of cognitive-emotional development that people experience as they relate to the world. These modalities or cognitive styles are not age-related, they are cyclical and not mutually exclusive, and it is possible to function in more than one simultaneously. Each person has a preferred modality, however, and the preferred modality is situation specific. A person can prefer or function in one modality in one set of circumstances and another modality in other circumstances. When an individual is unable to process an issue from the perspective of one or more modalities, he or she is considered to be experiencing a developmental block, and counseling becomes a process of facilitating the removal of these blocks (Ivey, 1999; Myers, 1998).

The four developmental modalities in DCT are *sensorimotor*, *concrete*, *formal operations*, and *dialectic/systemic* (Ivey, 1991). Sensorimotor refers to body or felt sensations, or feelings. Feelings are physically embedded and represent an in-body experience. The concrete modality is one in which people can relate linear, sequential details of life experiences. In the later aspects of this stage, people can engage in causal reasoning (i.e., if-then thinking). In the formal operational modality, people are able to see their patterns of behavior, thought, and feeling and to reflect on the meaning of those patterns. The dialectic/systemic modality is reflected in one's ability to take multiple perspectives and see multiple aspects of people and situations. In addition, persons who think dialectically are able to view themselves in systems and understand the impact of systems, and multiple interacting systems (e.g., gender, culture, family), on their behavior and functioning.

Developmental blocks, the inability to experience a particular event or circumstance in one, two, three, or all four modalities, may be experienced regarding specific situations or issues (Myers, 1998). A client experiencing a sensorimotor block will present either as unable to experience and deal appropriately with feelings or as being overwhelmed or immobilized by her or his feelings. A client who has a concrete block will be unable to provide linear, sequential details of events and will be unable to link cause and effect through if-then thinking. Clients experiencing formal operational blocks will be unable to reflect on and understand their own repeating patterns. Furthermore, although they may understand their patterns of behavior, cognitions, or feelings, they may become so involved in the process of self-examination that they may fail to take action relative to those patterns. Finally, clients who are blocked at the dialectic systemic level may be unable to see themselves in systems or understand the impact of multiple, interacting systems on their behaviors.

As an example of the nature of developmental blocks, David (Case Example 2) seems to have experienced a sensorimotor block, because he was unable to resolve his anger toward his mother and used the defense of repressing angry emotions in other contexts as well. However, he might be able to recount the details of his childhood abuse (concrete), explain his pattern of dealing with subsequent anger (formal operational), and explain the way that he responds in relation to how other family members respond (dialectic). This same individual may, as an adult, repress his anger and fail to understand how earlier models of anger influence how he reacts as an adult. Ivey (1999) might describe David as operating under a powerful system of "rules" for responding to situations, rules that were learned in his family. Additional examples of developmental blocks are provided in a later discussion of the application of DCT with each case example.

When a client presents for counseling, the first task is to assess her or his primary cognitive-developmental style, which Ivey (1991) noted that counselors can identify after the client speaks 50 to 100 words in the initial interview.

Alternately, a structured assessment may be used to help the counselor identify preferences for modalities and developmental blocks and to help the client examine his or her assumptions and develop new ways of thinking about problem situations. The structured sequence of questions is both an assessment and an intervention and is the foundation for designing a positive treatment plan for the client (Ivey, 1991). Intentional interventions include matching a client's preferred cognitive orientation to establish rapport and mismatching that preference to promote developmental change to new orientations and new ways of constructing meaning, or second order change.

After an assessment of the client's preferred modalities and possible developmental blocks, the DCT model provides a paradigm for planning and implementing interventions. Ivey (1991, 1999) linked preferred theories and interventions with each of the four modalities and emphasized that the selection of an appropriate intervention matched to the modalities of the client would be likely to result in successful outcomes. For example, a client functioning in the sensorimotor modality or a client with a block in this modality could benefit from interventions that would involve the body and senses, such as relaxation, music therapy, or Gestalt interventions that help clients experience emotions in the present. Clients who are primarily concrete respond most readily to problem-solving methods, including reality therapy and behavioral interventions. Formal operational clients may respond more quickly to interventions such as client-centered approaches, while dialectic clients may find systemic approaches, racial or feminist identity development, and networking strategies to be most effective. Ivey (1991) also identified the occurrence of formal preoperational cognitions whereby clients think abstractly about their situation yet fail to act on their knowledge. Although such clients' preferred modality is formal operational, more helpful interventions are likely to be those associated with the sensorimotor or concrete operational modalities. Thus, the selection of interventions is based on the developmental assessment.

USING DCT FOR ASSESSMENT AND INTERVENTION WITH CLIENTS EXPERIENCING SPIRITUAL BYPASS

Developmental assessment begins with the creation of an image (Ivey, 1991). Clients are asked to reflect on their presenting issue and begin to develop an image of one time when the issue was a concern. The task of the counselor is to facilitate exploration of the image in the here and now, through use of present-tense language to reflect on and build the image. Clients are encouraged to explore the image in the sensorimotor modality by responding in sequence to three key questions as these questions relate to the image: What are you seeing? What are you hearing? What are you feeling? A final question (once the counselor has clearly assessed that the client is in the present and emotionally connected with the image) is, Can you locate that feeling in your body?

The sensorimotor questioning sequence sets the stage for a process in which clients can get in touch with feelings and felt-body experiences, then examine the feelings through each of the other three DCT modalities to develop a deep sense of understanding about how those feelings initially arose; how they manifest in daily life; and how they might be changed, if desired, in the direction of more positive and intentional experiencing. Thus, the assessment/intervention process of the structured DCT interview sets the stage for addressing spiritual bypass in a positive manner. As Michaelson (1999) observed, "Rather than running from our feelings and self-defeating behaviors, we need to acknowledge them, discover where they came from, and learn the meaning behind them" (Discriminating Against Negative Feelings section, ¶10). DCT thus provides a clear and structured means of helping clients avoid engaging in pseudospirituality or sabotaging their spiritual growth (Michaelson, 1999).

In essence, then, spiritual bypass may be conceptualized as a developmental block, which may occur in any of the four DCT modalities but is likely to have a strong sensorimotor component in addition to possible blocks in other areas. The developmental blocks help the client avoid areas of suffering (Kornfield, 1993). The idea of a block is consistent with Poitou's (1997) suggestion that bypass

occurs when personal emotional issues are avoided by diverting energy and attention to what amounts to a spiritual tranquilizer, . . . avoiding the problem by . . . any activity related to the spiritual or religious that they feel gives them permission to avoid dealing with personal issues. For the individual in a spiritual bypass, all things are of a spiritual nature and any problems can be solved through spiritual means. (p. 6)

By engaging clients through developmental assessment, their spiritual experiences can be integrated with personal problems and issues, resulting in new experiences of the self and new perspectives on their patterns of behavior, cognition, and feelings.

The second stage of the DCT intervention helps the client attach meaning to her or his feelings by asking for a second example of a time when the same physically embedded feeling occurred. The client is asked to describe that time in a linear, concrete manner, focused not on sensorimotor experiencing but rather on the sequence of events related to the experience. The goal is to help the client explore the causal nature of her or his thoughts, feelings, and behaviors by reflecting on what happened, on the antecedent events, and on the consequent outcomes. The goal of this exploration is to help the client develop a conception that *if* he or she does a particular thing, *then* a predictable sequence of consequent outcomes occurs. Vaughn (1995) described this in relation to spiritual bypass as an information-seeking process, again with a goal of ascribing meaning to one's experiences.

In the third phase of the DCT assessment/intervention, the client is asked to reflect on similarities between the two experiences described earlier—the first being the image for which a sensorimotor feeling was identified and felt and the second being an example of another time the same feeling was experienced.

What is desired at this point is for the client to identify patterns of thoughts, feelings, and behaviors relative to the initial image. This process allows the client to develop insight into the nature of her or his repeating behaviors, which typically are triggered by feelings she or he may or may not be aware of. This awareness of one's patterns contributes to achieving authentic spirituality, or "being open to experiencing and learning about self, others, and God" (Harris, 1994, p. 78).

During the first three phases of the DCT intervention, the client is asked to focus internally and reflect on feelings, experiences, and patterns. In the fourth modality, the client is asked to step outside of her- or himself and reflect on how those patterns developed. Piaget (1952) and Ivey (1991, 1999) noted that 25% of the population will not reach fully formal operational thinking. As a consequence, these clients may be unable to achieve dialectic thinking regarding their presenting issue, in this case spiritual bypass. For those clients, the DCT process through the first three modalities will still help the client integrate body-based and psychological experience, which Harris (1994) identified as essential for healing the spiritual bypass.

Those clients who do achieve a dialectic perspective will acquire a deeper sense of meaning concerning their spiritual development. The first questions in the dialectic modality require clients to focus on the origins of their patterns, then lead to the identification, through a coconstructive process, of "rules" that guide the experiences of their behaviors, thoughts, and feelings. Deconstruction follows, whereby clients are helped to challenge their rules and begin the therapeutic process of finding more effective ways of solving the problems and the dilemmas of life.

APPLICATION OF DEVELOPMENTAL ASSESSMENT/INTERVENTION TO CASE EXAMPLES

The application of DCT to the three clients described earlier may further clarify both the etiology of spiritual bypass and how interventions might be formulated. In the case of Kim, whose compulsive and addictive behaviors were ascribed to her need to be "compulsively good," the image coconstructed for intervention involved one of the times she provided service to an isolated, homebound member of her church. The feelings associated with that experience were positive; she felt needed, and when asked to embed that feeling in her body, she described a "lightness and glowing sensation throughout her body." Asked for a second example of when she felt the same way, Kim gave another example of service to others. The concrete questioning sequence led to an exploration of outcomes or consequences, one of which was Kim's resentment toward her family for not supporting her.

Because the presenting problem was related to the family disruption, the counselor chose to explore the second feeling further, again using the DCT questions regarding what the client was seeing, hearing, and feeling in regard to a specific image of relating to her husband when she came home from her church activity. When asked to physically embed this feeling, Kim described a sharp pain in her chest, which she quickly negated

because as she said, "I know I am doing God's work." It was easy to find a second example of a time she felt the pain in her chest, again when she came home from her volunteer work and encountered her husband and children. Exploration of the pattern led to her statement that "when I am engaged in God's work, then my family suffers as a consequence." From a dialectic perspective, she identified a rule, learned in her family of origin, that "being good and trying to please others" was more important outside the family than inside, because within her alcoholic family of origin, it was never possible to consistently please others. On the other hand, when she served others, their accolades were always positive.

Through the DCT process, Kim was able to deconstruct her rule, observing that the rule was necessary to her emotional survival as a child but was destructive in her adult relationships. Rather than dealing with those relationships, she had been ignoring her earthly needs while rationalizing her behavior as due to an enlightened sense of spirituality, or what was defined earlier as premature transcendence, a condition of spiritual bypass. Once aware of this situation, the counselor was able to coconstruct a treatment plan to help Kim begin to change her rule and develop new and healthier ways both of relating to others (her earthly self) and relating to her God (her spiritual self).

Similar processes could be described for the cases of David and Joanna. In each case, DCT was used to help the client obtain an image of a time that his or her problem or issue occurred (i.e., anger at his wife and anger toward men, respectively), followed by facilitation of sensorimotor experiencing. Feelings associated with the image were physically embedded, then a second example of another time those same feelings had occurred (concrete modality) was described. The clients were helped to identify patterns of behaviors, thoughts, and feelings (formal operational modality), then to reflect on how those patterns developed (dialectic modality). The deconstruction of their rules led to the development of a treatment plan to help each client overcome his or her spiritual bypass and develop more effective ways of relating to others as well as healthier spirituality and paths to spiritual development.

David (Case Example 2), who had a sensorimotor block in that he experienced anger and was unable to control his angry feelings, was able to experience his anger in the session, provide examples of when the anger occurred (concrete processing), and reflect on his pattern of becoming angry with women (formal operational processing). Exploration at the dialectic systemic cognitive modality helped him develop an awareness of how his pattern of anger responses developed in relation to his mother. His unspoken "rule" was this: "Women are mean and capricious. When they do things I don't like, it makes me angry; but I have to hide it or bad things can happen." Through counseling, David was helped to deconstruct this rule and find a rule more useful and meaningful for his marriage as well as other relationships with women. He also learned to find appropriately assertive ways to express his feelings and discriminate between disappointment and anger in situations with his wife.

Joanna (Case Example 3) was a resistant client who refused to deal with her feelings, except for the feelings of enlightenment that reinforced her spiritual bypass. DCT was still an appropriate intervention, and the development

assessment/intervention sequence was processed using her feelings of enlightenment as a focus. After using the DCT questioning sequence to help her explore these feelings in the here and now, Joanna was helped to physically embed the sensations she was experiencing. She described an image of a time when she was providing "spiritual counseling," and she felt a sensation of lightness and expansiveness in her chest and head. When asked to describe another time she felt the same way, she talked about a dissociative state during a childhood episode of abuse (concrete example). When questioned about the similarity between the image and the abuse episode, she indicated that in both instances she was connected with something greater than herself (feelings) and she was able to be in control of her responses (behaviors and cognitions). Exploration at the dialectic level led to a greater understanding of how her patterns had developed and clarification of the following rule: "When I am threatened, I can experience an altered state of consciousness that allows me to transcend what is happening and connect with a Higher Power." Deconstruction of this rule was difficult, because Joanna felt that it was a good rule and one that helped her achieve her goals and follow her spiritual "calling." In this instance, although Joanna was helped to understand the relationship between her history of abuse and her felt call, counseling was terminated without change because she was unwilling to examine her abuse history as anything other than the enabling force behind her ability to empathize with women and help them develop their spiritual selves. In effect, she felt that her own abuse allowed her to understand others in a way that most helpers, secular or spiritual, were unable to do.

CONCLUSION

Clients experiencing spiritual bypass unconsciously use spiritual experiences, beliefs, and practices to avoid addressing their emotional wounds. From the perspective of traditional approaches to therapy, their problems may be incorrectly assessed and treated in ways that leave their wounds intact while allowing them to function in ways that seem, from an external perspective, to be satisfactory if not spiritually healthy. DCT provides an alternative perspective for dealing with these issues, promoting experiencing of emotional pain from multiple perspectives, with the potential outcome of greater meaning attached to one's internal experience. The outcome of greater self-understanding includes insights into the nature of spiritual bypass and the development of new interventions to promote healthy spirituality.

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